

IDAHO DEPARTMENT OF

HEALTH & WELFARE

C.L. "BUTCH" OTTER - Governor RICHARD M. ARMSTRONG - Director DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

January 12, 2009

Michael Dempsey Family Home Health 2950 East Magic View Drive, Suite 192 Meridian, Idaho 83642

Provider #137079

Dear Mr. Dempsey:

On **December 30, 2008**, a complaint survey was conducted at Family Home Health. The complaint allegations, findings, and conclusions are as follows:

Complaint #ID00003828

Allegation #1: The agency nurses did not provide a through assessment of patient needs to include a review of patient's medications.

Findings: An unannounced visit was made at the agency on 12/29/08 thru 12/30/08. Five clinical records, policies and procedures, complaint and grievances were reviewed.

Observations of staff and patient's were made and patients', staff and physicians' were interviewed.

One patient's record documented a 67 year-old female who was admitted to the agency on 9/30/08, following a left total knee revision. Review of the initial comprehensive assessment, which was conducted by the registered nurse, revealed the following responses to listed assessment items:

- a.) Patient lives with: Lives alone.
- b.) Primary Caregiver: No one person.
- c.) Ability to Dress Upper Body: Able to dress upper body without assistance if clothing is laid out or handed to the patient.

- d.) Ability to Dress Lower Body: Someone must help the patient put on undergarments, slacks, socks or nylons, and shoes.
- e.) Bathing: Able to bathe in shower or tub with the assistance of another person to get in and out of the shower or tub.
- f.) Transferring: Transfers with minimal human assistance or with use of an assistive devise
- g.) Feeding or eating: Able to feed self independently but requires meal set up.
- h.) Planning and preparing light meals: Unable to prepare any light meals or reheat any delivered meals.
- i.) Laundry: Unable to do any laundry due to physical limitation.
- j.) Housekeeping: Unable to effectively participate in any housekeeping tasks.
- k.) Shopping: Unable to go shopping.

The initial comprehensive assessment did not state who would provide the above needs or how the above needs would be met. A "PATIENT COMPLAINT/PROBLEM RESOLUTION REPORT", dated 10/13/08, stated that the patient had not received HHA (Home Health Aide) services 2-4 hrs (Hours) per day per the patient's request. The nurse who did the patient's initial comprehensive assessment was interviewed. He stated the patient thought the agency was there to "clean her house". He said he thought the patient had a boyfriend who was bathing and dressing the patient and a 10-year-old grandson to do errands. He stated the patient did not request additional services at the time of the comprehensive assessment but did not document this information.

It was determined the agency failed to ensure that initial comprehensive assessment had thoroughly described the health care status needs and how those needs were being met for the patient.

Additionally, the patient's medication orders were reviewed. The patient's record contained a list of medications titled, "(Hospitals name) Admission and Discharge Medications Reconciliation Orders". This list was provided by the hospital to the agency and was faxed to the agency. Further, the record contained a "DISCHARGE PRESCRIPTION" form, from the discharging hospital. These two forms listed the patient's medications and matched with the agency "MEDICATION PROFILE", done Additionally, the patient's POC (Plan of Care), also matched the by an RN. medications listed on the RN's medication profile review. However, the record also contained an "Interagency Transfer Physician Orders", stating the patient was to take Aspirin 325 mg twice a day for one month. The Aspirin was not on the patient's POC or the agency's "MEDICATION PROFILE". The nurse who reviewed the patient's medications was interviewed. He stated he did not know the patient was to take Aspirin twice a day for one month, nor did he recall seeing the physicians order to do so. The patient stated she did not know that she was to have taken Aspirin twice a day for a month, nor did she. The patient's physician was interviewed.

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He stated he had ordered the patient to take Aspirin 325 mg twice a day for a month to prevent the development of deep vein thrombosis. Additionally, three other records that were reviewed, documented the agency's medication records did not reflect with what the patient was actually taking. It was determined that the agency failed to ensure that patients' medications were fully reviewed to identify any potential medication complications for 4 of 5 sampled patients.

A deficiency was cited at G-331 and G-337 for the failure of the agency to ensure that initial comprehensive assessments had an accurate review of patient medications and had thoroughly described the patient's health care needs and how those needs were to be met.

Conclusion: Substantiated. Federal and State deficiencies related to the allegation are cited.

Allegation #2: Physical Therapy (PT) services were not provided as ordered. The agency's Physical Therapist would not show up to appointments and when he did he did very little treatment.

Findings: One record documented a 67 year-old female who was admitted to the agency on 9/30/08, following a left total knee revision. The record contained a "Physical Therapy Assessment/Plan of Care (POC)", signed and dated by the physician on 10/6/08. The POC stated the Physical Therapist was to see the patient 2 times a week for 1 week and then 3 times a week for 2 weeks. It stated the physical therapist would provide active and passive range of motion, gait training and use and instruct the patient in the use of a Continuos Passive Motion (CPM) machine. The record contained "MISSED VISIT" sheets, dated 10/2, 10/10, 10/15 and 10/17/08. The forms stated the client declined visits because of feeling sick or not being at home at the time of the visit. Therapy visit notes dated 10/6, 10/8 and 10/13/08 documented the therapist followed the patient's POC as ordered by the physician. The patient's physician was called on 12/30/08 at 2:05 PM. He stated he was pleased with the patient's progress and had no concerns about her therapy needs. The Physical Therapist was observed giving cares in three different homes on 12/30/08. The therapist followed each patient's POC. Additionally, each patient reported they were pleased with the therapy services.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Allegation #3: The agency's Physical Therapist caused a patient's hip to dislocate.

Findings: One record documented a 67 year-old female who was admitted to the agency on 9/30/08, following a left total knee revision. The record contained a faxed letter to the patient's physician dated 10/16/08.

Michael Dempsey January 12, 2009 Page 4 of 4

The letter stated that on 10/8/08 the patient complained of "severe pain in left hip" and went to the physician's office where she received treatment. The letter also stated on 10/13/08, the patient had complained of "left hip pain" and the stomach flu and had been in contact with her physician. On 12/30/08 at 2:05 PM the patient's physician was interviewed. He stated the patient did have left hip pain but he felt it was caused by spinal issues rather then a hip joint. He stated that it would have been near to impossible for the physical therapist to have caused injury to the patient during therapies.

Conclusion: Unsubstantiated. Lack of sufficient evidence.

Based on the findings of the complaint investigation, deficiencies were cited and included on the survey report. No response is necessary to this complaint report, as it was addressed in the Plan of Correction.

If you have questions or concerns regarding our investigation, please contact us at (208) 334-6626. Thank you for the courtesy and cooperation you and your staff extended to us in the course of our investigation.

Sincerely,

PATRICK HENDRICKSON Health Facility Surveyor Non-Long Term Care SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

PH/mlw



C.L. BUTCH OTTER, GOVERNOR RICHARD M. ARMSTRONG - Director

DEBRA RANSOM, R.N.,R.H.I.T., Chief BUREAU OF FACILITY STANDARDS 3232 Elder Street P.O. Box 83720 Boise, ID 83720-0036 PHONE 208-334-6626 FAX 208-364-1888

January 12, 2009

Michael Dempsey Family Home Health 2950 East Magic View Drive, Suite 192 Meridian, Idaho 83642

RE:

Family Home Health, provider #137079

Dear Mr. Dempsey:

This is to advise you of the findings of the complaint survey at Family Home Health which was concluded on December 30, 2008.

Enclosed is a Statement of Deficiencies/Plan of Correction, Form CMS-2567, listing Medicare deficiencies and a similar form listing State licensure deficiencies. In the spaces provided on the right side of each sheet, please provide a Plan of Correction. It is important that your Plan of Correction address each deficiency in the following manner:

- 1. Answer the deficiency statement, specifically indicating how the problem will be, or has been, corrected. Do not address the specific examples. Your plan must describe how you will ensure correction for <u>all</u> individuals potentially impacted by the deficient practice.
- 2. Identify the person or discipline responsible for monitoring the changes in the system to ensure compliance is achieved and maintained. This is to include how the monitoring will be done and at what frequency the person or discipline will do the monitoring.
- 3. Identify the date each deficiency has been, or will be, corrected.
- 4. Sign and date the form(s) in the space provided at the bottom of the first page.

Michael Dempsey January 12, 2009 Page 2 of 2

After you have completed your Plan of Correction, return the original to this office by **January 26, 2009**, and keep a copy for your records.

Thank you for the courtesies extended to us during our visit. If you have any questions, please call or write this office at (208)334-6626.

Sincerely,

PATRICK HENDRICKSON Health Facility Surveyor Non-Long Term Care SYLVIA CRESWELL

Co-Supervisor

Non-Long Term Care

PH/mlw

Enclosures

PRINTED: 01/08/2009 FORM APPROVED OMB NO. 0938-0391

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:		(X2) MULTIPLE CONSTRUCTION A. BUILDING		(X3) DATE SURVEY COMPLETED				
137079		B. WING		C				
NAME OF P	ROVIDER OR SUPPLIER	1570/3		TREET ADDRESS, CITY, STATE, ZIP C		0/2008		
FAMILY HOME HEALTH				2950 EAST MAGIC VIEW DR STE				
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G 000	INITIAL COMMEN	rs	G 00	00				
	complaint survey of	encies were cited during the fyour Home Health Agency. eyors conducted the survey:						
	Patrick Hendrickson R.N., H.F.S. Acronyms used in this report include:							
				See Attached	See Alfra V			
	DNS = Director of N mg = Milligrams POC = Plan of Care RN = Registered N SOC = Start of Care	e urse		Joo HTTGENED				
G 331	484.55(a)(1) INITIA	L ASSESSMENT VISIT	G 33	31				
	assessment visit to and support needs Medicare patients,	must conduct an initial determine the immediate care of the patient; and, for to determine eligibility for the alth benefit, including						
	Based on review of policies and staff in agency failed to en assessments had to care status needs a being met for 1 of 8	is not met as evidenced by: medical records, agency iterview, it was determined the sure that initial comprehensive horoughly described the health and how those needs were patients (#1), whose records e findings included:						
	admitted to the age total knee revision. comprehensive ass by the registered no the following respo	67 year-old female who was ency on 9/30/08, following a left Review of the initial sessment, that was conducted urse on 9/30/08, documented nses to listed assessment				AVO DATE		
LABORATOR	ORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE TITLE (X6) DATE							

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

ADMINISTRATON

1-15-09

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		(X2) MULT	IPLE CONSTRUCTION IG	(X3) DATE SURVEY COMPLETED		
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NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH			2	REET ADDRESS, CITY, STATE, ZIP CODE 1950 EAST MAGIC VIEW DR STE 192 MERIDIAN, ID 83642		
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G 331	items: a.) Patient li Primary Caregiver: Dress Upper Body: without assistance to the patient. d.) A Someone must hel undergarments, sla shoes. e.) Bathing tub with the assista and out of the show Transfers with mini use of an assistive Able to feed self int set up. h.) Plannin Unable to prepare a delivered meals. i. laundry due to phys Housekeeping: Una any housekeeping go shopping. The a ASSESSMENT AN COLLECTION; ST, was undated, state specific data to det continuing health c comprehensive ass would provide the a needs would be me The patient was int at 1:50 PM. She si without being bathe	No one person. c.) Ability to Able to dress upper body if clothing is laid out or handed ability to Dress Lower Body: p the patient put on acks, socks or nylons, and a Able to bathe in shower or noce of another person to get in a ver or tub. f.) Transferring: mal human assistance or with devise. g.) Feeding or eating: dependently but requires meal g and preparing light meals: any light meals or reheat any and preparing light meals: any light meals or reheat any able to effectively participate in tasks. k.) Shopping: Unable to agency's "COMPREHENSIVE D OASIS DATA ART OF CARE" policy, that d'gather and analyze ermine the initial and are needs". The initial sessment did not state who above needs or how the above et.	G 331			
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PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) G 337 Continued From page 5 last reviewed the patient's medications on 7/7/08. However, the medication profile dated 7/7/08, and the patient's POC, dated 11/16/08, listed the patient's medications as the same with no variances. On 12/30/08 at 10:54 AM, a home visit was made to the patient's residence. The patient's medications were reviewed with the patient and the following discrepancies were				2	950 EAST MAGIC VIEW DR STE 192		
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A. The patient was taking 1000 mg of vitamin C once a day. This was not listed on any medication lists, nor on the patient's POC. The patient said she had been taking this medication for as long as she could remember. B. The patient was taking 12000 to 45000 mg of Cranberry once a day as needed for treatment of urinary tract infections. This was not listed on any medication lists, nor on the patient's POC. The patient said she had been taking this medication for as long as she could remember. C. The patient was taking Green Tea extract 300 mg once a day. This was not listed on any medication lists, nor on the patient's POC. The patient said she had been taking this medication for as long as she could remember. D. The patient was taking L-Lysin 1000 mg once a day as needed for treatment of cold sores. This was not listed on any medication lists, nor on the patient's POC. The patient's POC. The patient said she had been taking this medication for as long as she could remember. E. The patient was taking Flaxseed Oil 1000 mg once a day. This was not listed on any medication for as long as she could remember. E. The patient was taking Flaxseed Oil 1000 mg once a day. This was not listed on any medication lists, nor on the patient's POC. The	G 337	last reviewed the pathowever, the medication variances. On 12/3 visit was made to the patient's medication patient and the follor observed: A. The patient was once a day. This was medication lists, no patient said she had for as long as she of the patient was cranberry once a durinary tract infection medication lists, no patient said she had for as long as she of the patient was might once a day. The patient was might once a day. The patient was a day as needed for was not listed on an patient's POC. The taking this medication was once a day. This was once a day.	atient's medications on 7/7/08. Cation profile dated 7/7/08, and dated 11/16/08, listed the is as the same with no 80/08 at 10:54 AM, a home ine patient's residence. The is were reviewed with the owing discrepancies were staking 1000 mg of vitamin C is not listed on any ron the patient's POC. The id been taking this medication could remember. Itaking 12000 to 45000 mg of ay as needed for treatment of ins. This was not listed on any ron the patient's POC. The id been taking this medication could remember. Itaking Green Tea extract 300 is was not listed on any ron the patient's POC. The id been taking this medication could remember. Itaking Green Tea extract 300 is was not listed on any ron the patient's POC. The id been taking this medication could remember. Itaking L-Lysin 1000 mg once retreatment of cold sores. This my medication lists, nor on the expatient said she had been on for as long as she could itaking Flaxseed Oil 1000 mg as not listed on any	G 337			

NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE 2950 EAST MAGIC VIEW DR STE 192 MERIDIAN ID 83642	STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:			(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY COMPLETED	
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FAMILY HOME HEALTH 2950 EAST MAGIC VIEW DR STE 192	137079		B. WING	G				
MEDIDINA, ID 03042					295			
PRÉFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTIVE ACTION SHOULD BE COMPLE	PRÉFIX	(EACH DEFICIENC)	/ MUST BE PRECEDED BY FULL	PREFIX	×	(EACH CORRECTIVE ACTION SHOU CROSS-REFERENCED TO THE APPR	JLD BE	(X5) COMPLETION DATE
G 337 Continued From page 6 patient said she had been taking this medication for as long as she could remember. F. The patient was taking Calcium 1800 mg once a day. This was not listed on any medication lists, nor on the patient's POC. The patient said she had been taking this medication for as long as she could remember. G. The patient was taking Lisinopril/Hctz 10/12.5 mg once a day. This was listed on the 7/7/08 medication profile and the 11/6/08 POC as "Lisinopril/Hctz 20/12.5 mg once a day." The prescription was changed on 9/3/08. H. The patient was taking Femara 2.5 mg every other day. This was listed on the 7/7/08 medication profile and the 11/6/08 POC as "Femara 2.5 mg every day." The patient stated the prescription was changed a year ago. I. The 7/7/08 medication profile and the 11/6/08 POC as "Femara 2.5 mg every 6 hours. The patient did not have this medication in the home and reported she had not taken this medication for a long time. On 12/30/08, beginning at 2.46 PM, the nurse who reviewed the patient's medications on 7/7/08 and 11/06/08 was interviewed. He could not find documentation that he had reviewed the patient's medications on the 7/7/08 medication review and the 11/6/08 POC. He was not aware that the patient was taking the above listed medications. 4. Patient #4 was a 77 year-old female who was admitted to the agency on 12/19/08, for physical	G 337	patient said she hat for as long as she of as long as she of F. The patient was a day. This was not on the patient's had been taking this she could remember G. The patient was mg once a day. The medication profile a "Lisinopril/Hctz 20/prescription was other day. This was medication profile a "Femara 2.5 mg eventhe prescription was other prescription was discrepanted to the patient of the patient was not savered the patient of the patient was not aware above listed medication. He was not aware above listed medication.	d been taking this medication could remember. taking Calcium 1800 mg once of listed on any medication lists, POC. The patient said she is medication for as long as er. staking Lisinopril/Hctz 10/12.5 ais was listed on the 7/7/08 and the 11/6/08 POC as 12.5 mg once a day." The langed on 9/3/08. taking Femara 2.5 mg every is listed on the 7/7/08 and the 11/6/08 POC as 13/2 are day." The patient stated is changed a year ago. cation profile and the 11/6/08 cient was taking Oxycodone 5. The patient did not have this ome and reported she had not on for a long time. cation profile and the nurse patient's medications on 7/7/08 and reviewed. He could not find the had reviewed the patient's 6/08, and could not explain the patient's medications on the review and the 11/6/08's POC. that the patient was taking the ations.	G 3	37			

STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		1.	LTIPLE CONSTRUCTION		(X3) DATE SURVEY COMPLETED	
		A. BUILE		- с		
137079			B. WING	-	12/3	30/2008
NAME OF PROVIDER OR SUPPLIER FAMILY HOME HEALTH			S	STREET ADDRESS, CITY, STATE, ZIP CO 2950 EAST MAGIC VIEW DR STE 1 MERIDIAN, ID 83642		
(X4) ID PREFIX TAG	(EACH DEFICIENCY	TEMENT OF DEFICIENCIES MUST BE PRECEDED BY FULL SC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CO (EACH CORRECTIVE ACTION CROSS-REFERENCED TO THE DEFICIENCY)	N SHOULD BE	(X5) COMPLETION DATE
G 337	therapy services for revision. The patie medications, dated name) Admission a Reconciliation Order the hospital and fax This list of medicati "MEDICATION PRO12/19/08. On 12/30 was made to the partient's medication patient and the patient and the patient and the patient wice a day. The 12/15/08 and the partient and the patient the hospital on 12/1 not listed on the number of 12/30/08 at 2:46 the patient's medication after the patient's medication the number of 12/30/08 at 2:46 the patient's medication.	llowing a right total knee nt's record contained a list of 12/18/08, titled "(Hospitals and discharge Medications ers". This list was provided by ked to the agency on 12/18/08. It is matched the agency OFILE", done by an RN on D/08 at 12:29 PM, a home visit atient's residence. The ns were reviewed with the ent's daughter. It was ent was taking Celebrex 200 his medication was started on atient continued to take the expatient was discharged from 18/08. This medication was rse's medication profile. S PM, the nurse who reviewed ations was interviewed. He now the patient was taking	G 33	37		

Bureau of Facility Standards (X3) DATE SURVEY STATEMENT OF DEFICIENCIES (X1) PROVIDER/SUPPLIER/CLIA (X2) MULTIPLE CONSTRUCTION COMPLETED AND PLAN OF CORRECTION IDENTIFICATION NUMBER: A. BUILDING B. WING 137079 12/30/2008 STREET ADDRESS, CITY, STATE, ZIP CODE NAME OF PROVIDER OR SUPPLIER 2950 EAST MAGIC VIEW DR STE 192 **FAMILY HOME HEALTH** MERIDIAN, ID 83642 SUMMARY STATEMENT OF DEFICIENCIES PROVIDER'S PLAN OF CORRECTION (X5) COMPLETE (X4) ID (EACH CORRECTIVE ACTION SHOULD BE (EACH DEFICIENCY MUST BE PRECEDED BY FULL PRÉFIX PREFIX DATE CROSS-REFERENCED TO THE APPROPRIATE REGULATORY OR LSC IDENTIFYING INFORMATION) TAG TAG DEFICIENCY) N 093 03.07024, SK. NSG. SERV. N 093 gee attached N093 01. Registered Nurse. A registered nurse assures that care is coordinated between services and that all of the patients needs identified by the assessments are addressed. A registered nurse performs the followina: a. Makes the initial evaluation visit and regularly reevaluates the patient's nursing needs; This Rule is not met as evidenced by: Refer to Federal deficiency G 331, as it relates to the failure of the agency to ensure that initial comprehensive assessments had thoroughly described the patient's health care status needs and how those needs were being met. N 173 03.07030.07.PLAN OF CARE N 173 See arrached N173 07, Drugs and Treatments, Drugs and treatments are administered by agency staff only as ordered by the physician. The nurse or therapist immediately records and signs oral orders and obtains the physician's countersignature. Agency staff check all medications a patient may be taking to identify possible ineffective side effects, the need for laboratory monitoring of drug levels, drug allergies, and contraindicated medication and promptly report any problems to the physician. This Rule is not met as evidenced by: Refer to Federal deficiency G 337, as it relates to the failure of the agency to ensure medications

Bureau of Facility Standards

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIES REPRESENTATIVE'S SIGNATURE

TITLE

(X6) DATE

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(X3) DATE SURVEY

Bureau of Facility Standards

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION (X1) PROVIDER/SUPPLIER/CL IDENTIFICATION NUMBER 137079			A. BUILDING	PLE CONSTRUCTION G		URVEY ETED C 0/2008	
				DRESS, CITY, S	TATE, ZIP CODE	12/3	0/2000
	HOME HEALTH		2950 EAS		EW DR STE 192		
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES ID ((EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX REGULATORY OR LSC IDENTIFYING INFORMATION) TAG			PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CORRESTREFERENCED TO THE APPROPRIATE DEFICIENCY)		
N 173	Continued From pa	ige 1		N 173			
N 173	were reviewed to ic effects, drug reaction significant side effe	dentify any potential a ons, ineffective drug ects, significant drug ate drug therapy, or	adverse therapy,	N 173			
	The suppose of the su						

WPSW11

FAMILY HOME HEALTH COMPLAINT SURVEY PLAN OF CORRECTION

January 14, 2009

Prepared by: Carrie Birch, RN, Director of Clinical Services

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JAM 20 2009

CTANDARDS

G 331 484.55(a)(1) INITIAL ASSESSMENT VISIT N 093 03.07024 SK. NSG. SERV.

Deficiency: Agency failed to ensure that initial comprehensive assessments had thoroughly described the health care status needs and how those needs were being met.

Plan of Correction:

• It is the responsibility of the nurse who performs the initial home health assessment, to identify the patient's need for assistance through the "Supportive Assistance" and "Life System Profile" sections of the Start of Care Assessment. If the patient requires assistance as identified in (MO380) and if the patient is less than independent in (MO670) thru (MO810), but refuses the services of an aide or therapist, the nurse shall document, by name, the person or persons whom the patient identifies as those who will be assisting with these activities.

Person Responsible for Implementing/Monitoring Changes/Ensure Compliance:

- Director of Clinical Services
- Clinical Coordinator
- QA Director

Date of Deficiency Correction:

• 010609 (Inservice) and monitor on an ongoing basis

G 337 484.55(c) DRUG REGIMEN REVIEW N 173 03.07030.07 PLAN OF CARE

Deficiency: Agency failed to ensure patients' medications, including over-the-counter supplements, were reviewed to identify any potential medication complications.

Plan of Correction:

- Medication profiles shall include <u>all</u> prescribed medications, supplements, OTC and herbal remedies.
- All patient medications shall be categorized on the Medication Profile with the following key:
 - S- Prescriptions have been written but patient has not filled or not started
 - T- Medications being taken, but not prescribed by the physician
 - O- Medications prescribed but patient is not currently taking
 - P- Prescribed medications that patient is taking

- When completed by the nurse, the patient shall sign and date the Medication Profile as an indication of its completeness and accuracy.
- If the patient is opened on the weekend, the weekend nurse and the case manager will sign the Medication Profile.
- All "Interagency Transfer Physician Orders" and admission orders from the MD offices shall be "noted", initialed and dated by the case manager.
- If the patient is opened on the weekend, the weekend nurse **and** the case manager will "note" the transfer order/order for admission to home health.
- The Intake Coordinator or her designee will highlight specific services/interventions and medication orders listed on the transfer/admission order.
- If the patient resides in an ALF, the nurse shall provide documentation that the MAR has been reviewed with a member of the ALF staff, at least, 1-2 times a month and more frequently if the patient is known to have a labile medical condition and/or frequent changes to his/her medication regime (i.e. DM, Anticoagulation Therapy, uncontrolled pain, CHF, etc.). If the patient is receiving primarily therapy services, it will be the responsibility of the therapist to obtain a "copy" of the MAR, at least, 1-2 times a month and more frequently if the patient is known to have a labile medical condition and/or frequent changes to his/her medication regime. The "copy" will then be reviewed by a Family Home Health nurse to ensure that medication changes are identified.

Person Responsible for Implementing/Monitoring Changes/Ensure Compliance:

- Director of Clinical Services
- Clinical Coordinator
- QA Director

Date of Deficiency Correction:

- 010609 (In-service-Case Mangers) and monitor on an ongoing basis
- 011309 (Meeting-Therapists) and monitor on an ongoing basis